eClinicalWorks
Business Analysis Department

END USER WORKBOOK—OB FLOWSHEETS

Kentucky Department for Public Health—March 2017

CONTENTS

OB FLOWSHEETS WORKFLOWS

The following sections describe the end user OB Flowsheets workflows.

For more information about these workflows, and V10e, refer to the *eCW 101 OB Flowsheets Workbook* and the documentation available on the my.eclinicalworks.com Customer Portal.

> **Note:** For information about patient safety, refer to the Patient Safety Advisory Letter, available on the my.eclinicalworks.com Customer Portal.

Documenting the OB Flowsheets

The following sections describe the workflows for documenting in an OB Flowsheet.

Accessing the OB Flowsheet

Path: *Main Menu > Practice icon > Office Visits*

Access the OB Flowsheet by double-clicking on the patient name link in the Office Visits window:
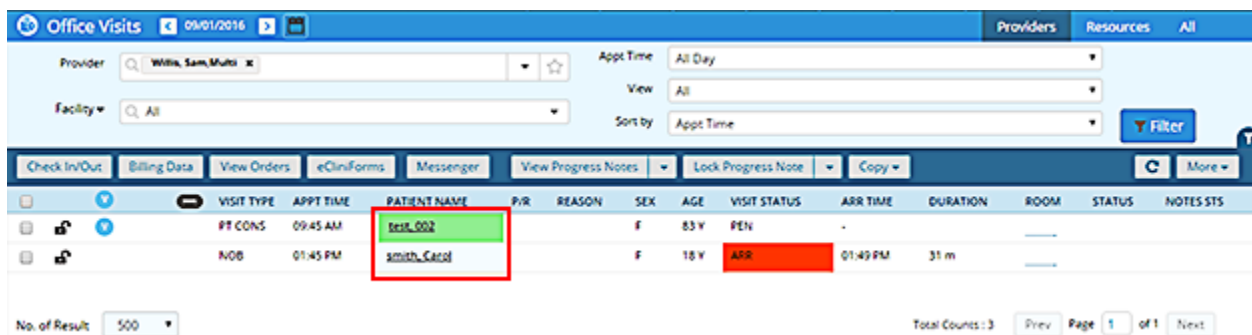
Use the Show/Hide toggle buttons next to the Patient Lookup icon to hide the Patient Dashboard and Interactive Clinical Wizard (ICW – formerly Right-Chart Panel).

Switch between the Progress Notes view and the OB view by clicking the *PN* or *OB* icon:

Entering Pregnancy Information

Create and document a pregnancy for this patient from the Pregnancy List tab.

Creating a New Pregnancy

Path: *OB Flowsheet > Preg List Tab*

Create a new pregnancy in the patient's OB Flowsheet.

To create a new pregnancy:

1. In the OB Flowsheet, click *Create Pregnancy*:

2. In the Preg List section, select the new pregnancy and click the *Edit* icon:

3. In the Preg Details window, enter the paternity details, the *Primary OB Provider*, and any additional details:

4. Click *OK* to save the new pregnancy.

Entering Total Pregnancy Information

Path: *OB Flowsheet > Edit pregnancy*

Enter the pregnancy conception and outcome details in the Form A window.

To enter information about the patient's pregnancies:

1. From the OB Flowsheet, select a pregnancy in the Preg List section and click the *Edit* icon.

2. In the Preg Details window, click the *Form A* tab.

3. Enter the additional information about the patient's previous pregnancies:

4. Click OK.

Entering Past Pregnancy Information

Path: *OB Flowsheet > Past Pregnancies*

Enter the pregnancy conception and outcome details in the Form A window.

To enter information about the patient's past pregnancies:

1. From the OB Flowsheet, in the Past Pregnancies section, click the plus (+) icon:

2. In the Past Pregnancy window, enter the specific information about the patient's previous pregnancies:

3. Click *OK* to save this information.

Patient History

Path: *OB Flowsheet > History tab*

Enter the patient's surgical, family, social, medical, gynecological, obstetrical, and hospitalization history in the History tab of the OB Flowsheet.

To enter the patient's historical information:

1. From the OB Flowsheet, click the *History* icon in the right navigation bar:
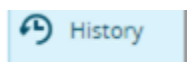
   The historical information from the Surgical History, Hospitalization History, Family History, Social History, Medical History, Allergies, and GYN History sections of the patient's past Progress Notes populate in the OB Flowsheet.

2. In the History tab, click the *Edit* icon next to a section to edit the patient's surgical, family, social, medical, gynecological, obstetrical, or hospitalization history:

3. In the OB Flowsheet History section, click the *Edit* icon:

4. In the History window, enter additional history information by selecting options from the drop-down lists and entering notes in the Remarks fields:

Entering Genetics Information

Path: *OB Flowsheet > Genetics tab*

Enter the patient's genetic in the Genetics tab of the OB Flowsheet.

To enter the patient's genetic information:

1. From the OB Flowsheet, click the *Genetics* icon in the right navigation pane:
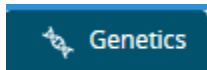
2. In the Genetics section, click the *Edit* icon:

3. In the Genetics window, enter the genetics information by selecting options from the drop-down lists and entering notes in the *Remarks* fields:

4. Click *OK* to save the information.

Calculating the Patient's Risk Assessment

Path: *OB Flowsheet > Risks*

Calculate the patient's risk assessment in the Risks tab of the OB Flowsheet.

To calculate the patient's risk assessment:

1. From the OB Flowsheet, click the *Risks* icon in the right navigation pane:
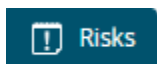
2. In the Risks section, click the *Edit* icon.

3. In the Risks window, enter the date next the assessment for which the patient is identified to be *At Risk* or *High Risk*.

4. (*Optional*) Check the box next to an assessment to add it to the patient's Problem List.

5. Click *OK*.

    The patient's risk is calculated. The list of risks display in the Summary section of the OB Flowsheet. High risks display in the *Problems* section, along with any risks that have been added to the patient's Problem List. High risks display in red.

Adding Problems to the Patient Record

Add OB problems to the patient record, or assessments to the patient's Problem List.

Adding OB Problems

Path: *OB Flowsheet > Problems*

Enter the patient's surgical, family, social, medical, gynecological, obstetrical, and hospitalization history in the History tab of the OB Flowsheet.

To add an OB problem to the patient's record:

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:
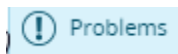
2. In the Problems section, click the first plus (+) icon:

3. In the OB Problem window, enter the patient's *Problem*, *Status*, *Initials*, and any *Action* taken for that problem:

4. Click *OK* to save the problem to the patient record.

5. In the Problems section, click the second plus (+) icon to add an assessment to the patient's Problem List.

Adding an Assessment to the Problem List

Path: *OB Flowsheet > Problems*

Add an assessment to the patient's Problem List in the Problems tab of the OB Flowsheet.

To add an OB problem to the patient's record:

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:
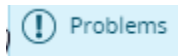
2. In the Problems section, click the second plus (+) icon.

3. In the Problem List window, click *Add ICD* to add a diagnosis code to the patient's Problem List:

4. Click *OK*.

Enter the Initial Physical Exam

Path: *OB Flowsheet > Physical*

Enter the patient's initial physical exam information, including the patient's height, BP, HEENT, *etc.*, in the Physical tab of the OB Flowsheet.

To add an OB problem to the patient's record:

1. From the OB Flowsheet, click the *Problems* icon in the right navigation pane:
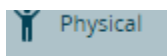
2. In the Physical section, click the *Edit* icon:

3. In the Physical window, enter the exam information by selecting options from the drop-down lists and entering notes in the *Remarks* fields:

4. (*Optional*) Click the *Merge Defaults* button to enter the defaults that have been configured in the OB Flow Admin window.

> **Note:** The Initial 'Physical' section is used for documenting certain examination items such as height, BP, HEENT etc.

Entering First, Second, and Third Trimester Plans

Path: *OB Flowsheet > Physical*

Enter the plans for the first, second, and third trimester in the Plans tab of the OB Flowsheet.

To add plans for the patient's first, second, and third trimesters:

1. From the OB Flowsheet, click the *Plans* icon in the right navigation pane:
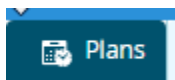
2. In the Plans section, click the *Edit* icon.

3. In the Plans window, enter the plans to educate the patient for all three trimesters.

| Note: | Scroll to display the second and third trimesters. |

OB Visits

Create a new visit, display the care graph, enter the estimated delivery date, order test, and manage medications from the Flowsheet tab.

Creating a New Visit and Entering Notes

Path: *OB Flowsheet > Physical*

Create a new OB visit and enter notes in the Flowsheet tab of the OB Flowsheet.

To create a new visit:

1. From the OB Flowsheet, click the *Plans* icon in the right navigation pane:

2. In the Plans section, click the plus (+):

3. In the Flow Sheet window, enter the findings from the visit, or click *Defaults*:

Note: The *Date* and *Gestational Age* fields automatically populate.

4. Click *OK*.

   The findings display in the Flowsheet.

5. (*Optional*) Check the *Vertical View* box to display the visit findings in a vertical grid:

6. From the OB Flowsheet, in the *Notes* section, click the plus (+) icon:

7. In the Notes window, enter any notes in the *Problem* field, and click *OK*:

Viewing the Care Graph

Path: *OB Flowsheet > Care Graph icon*

To display the care graph:

From the OB Flowsheet, click the *Care Graph* icon:

The patient's gestational age display in red at the top of the graph. Tests identified as requiring immediate attention display in the ASAP column, as well as overdue tests (*Go* orders display in green). Tests for which the patient's gestational age is still below the defined upper gestational age limit display in yellow:

Order labs that are due by selecting the *Order* tab in the *Status* column.

Entering the EDD

Path: *OB Flowsheet > EDD*

Calculate the estimated delivery date (EDD) in the EDD tab of the OB Flowsheet.

To enter the estimated delivery date:

1. From the OB Flowsheet, click the *EDD* icon in the right navigation pane.

2. In the EDD window, enter the date next to the LMP, Initial Exam, or Ultrasound that was used to determine the delivery date.

3. Click *Sel* in the row for that method to select the initial EDD.

4. Click *Make Final EDD* to mark this date as the final EDD:

5. (*Optional*) Click *Lock* to lock this EDD.

   > **Note:** The date must be unlocked to be changed after it's been locked. Do not lock the EDD until you are certain it will not be changed.

6. Click *OK*.

Ordering Lab Tests or Diagnostic Imaging

Path: *OB Flowsheet > Labs DI*

Order a lab or diagnostic imaging procedure in the Labs DI tab of the OB Flowsheet.

To order a lab test:

1. From the OB Flowsheet, click the *Labs DI* icon in the right navigation pane.

    OR

    If the lab is due based on the *Care Items Due* section, click *Order* next to the lab.

2. In the Labs DI section, click *Order Labs* or *Order Imaging*:

3. In the Order Lab window, click *Browse labs*:

4. In the Manage Orders window, enter the name of the order in the search field and click the order.

5. Click *Close*.

   The lab is ordered.

Managing Medications

Continue, refill, or stop current medications, or add new medications from the Treatment window.

Continuing, Refilling, or Stopping Current Medications

Path: *OB Flowsheet > Rx*

Continue, refill, or stop current medications in the Rx tab of the OB Flowsheet.

To continue, refill, or stop current medications:

1. From the OB Flowsheet, click the *Rx* icon in the right navigation pane:

   ℞ Rx
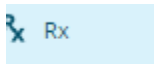
2. In the *Rx* section, click the *Edit* icon next to the *Current Medications* section to edit the patient's current medications.

3. Click the *Edit* icon next to the Allergies section to add allergies to the patient's record.

4. In the Treatment section, click the *Edit* icon to prescribe a new medication or enter instructions for a current medication:

   a. In the Treatment window, click *Cur Rx*:

   b. In the Manage Orders window, select the appropriate instruction for the patient's current medications:

   - C: Continue taking the medication

   - R: Refill

   - 30: 30-day Refill

   - 90: 90-day Refill

   - S: Stop taking the medication

   c. Click *OK*.

Adding New Medications

Path: *OB Flowsheet > Rx*

Continue, refill, or stop current medications in the Rx tab of the OB Flowsheet.

To add a new medication:

1. From the OB Flowsheet, click the *Rx* icon in the right navigation pane:

   ℞ Rx

2. In the Treatment section, click the *Edit* icon to prescribe a new medication or enter instructions for a current medication.

3. In the Treatment window, click *Add*, and select *Rx* from the drop-down list:
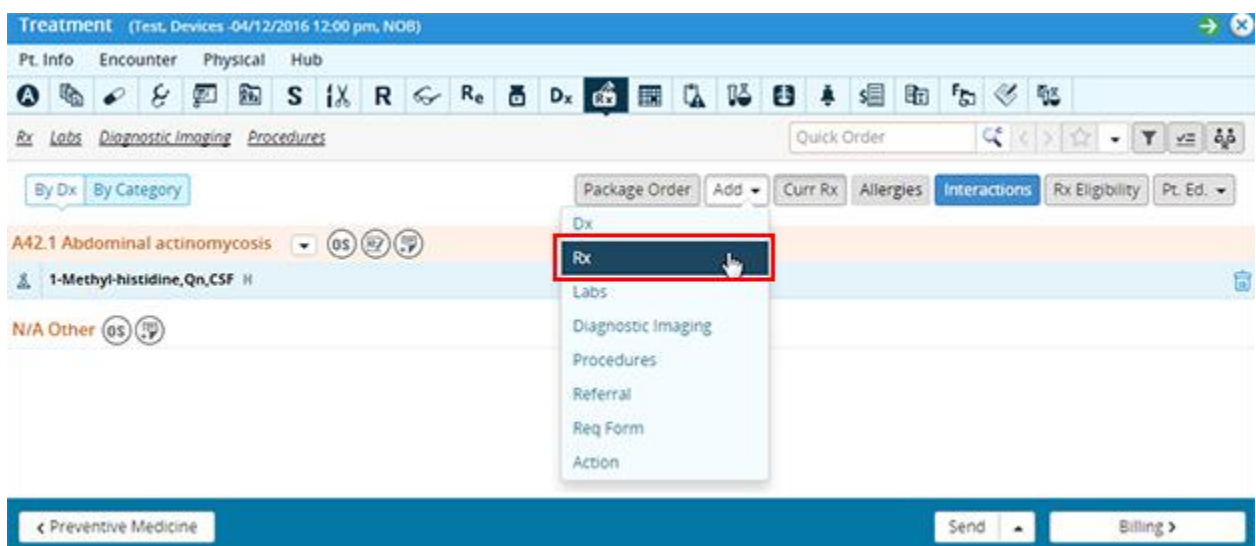
4. In the Manage Orders window, search for the medication in the *Quick Search* field:
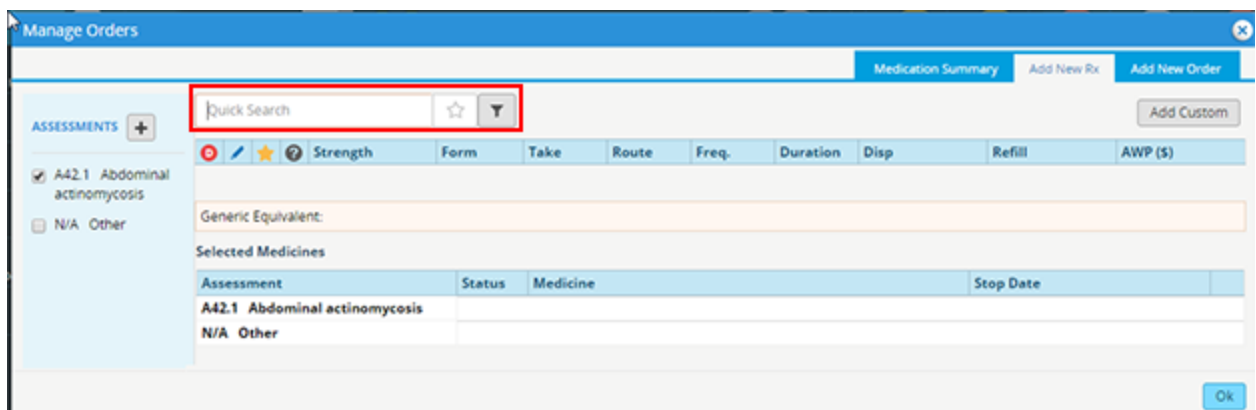
5. Select the correct dosage.

   The medication is added to the *Selected Rx* section of the window.

Post-Partum

Enter discharge information, post-partum findings, and close the pregnancy.

Entering Discharge Information

Path: *OB Flowsheet > Discharge*

Document the discharge information in the Discharge tab of the OB Flowsheet.

To enter discharge information:

1. From the OB Flowsheet, click the *Discharge* icon in the right navigation pane:

2. In the Discharge window, enter the discharge information:

Entering Post-Partum Information

Path: *OB Flowsheet > Post Partum*

Document the post-partum information in the Post Partum tab of the OB Flowsheet.

To enter post-partum information:
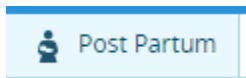
1. From the OB Flowsheet, click the *Post Partum* icon in the right navigation pane:

2. In the Post Partum window, enter the post-partum information by selecting options from the drop-down lists, and entering notes in the *Remarks* fields:

Closing the Pregnancy

Path: *OB Flowsheet > Preg Details*

Close the pregnancy in the Preg List tab of the OB Flowsheet.

To close the pregnancy:

1. From the OB Flowsheet, click the *Preg Details* icon in the right navigation pane:
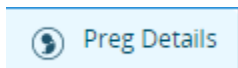
2. In the Preg List section, enter the discharge date for the pregnancy and click *Close Pregnancy*:

Printing or Faxing an OB Flowsheet

Path: *OB Flowsheet > Print icon*

Print or fax the OB Flowsheet.

To print or fax the OB Flowsheet:

1. From the OB Flowsheet, click the *Print* icon:

2. In the Pregnancy Summary Report window, select the report format and the sections to print:

3. From the *Send* drop-down list, click *Print* or *Fax*.

OBGYN Billing

Global Billing

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides the entire patient's obstetric care. Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to:

- The date of delivery.

- Routine urinalysis testing during the prenatal period.

- Care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, and vaginitis).

- The completion of the *Risk Appraisal for Pregnant Women* form.

Only one prenatal care code, 59425 (4-6 visits) or 59426 (7 or more visits), may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the participant goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

OBGYN Billing Workflow

Provider sees pregnant patient

Is this first visit?

YES → Provider needs to bill with a Dx code of 'pregnancy' and a E&M level with any additional CPT codes.

NO

Each additional visit during the antepartum period, provider should use CPT 99499, along with any additional CPT codes.

NO

Has patient delivered baby?

YES

Provider bills CPT 59425 (4-6 visits during antepartum period) or 59426 (7 or more visits during antepartum visits), may be billed per pregnancy.

Note: Date of delivery is the Date of Service to be used when billing global prenatal codes.

OB Down Payment Workflow

The workflow below represents how to apply payments for patients who are on a payment plan (optional).

Patient gives payment for down payment.

↓

Create an 'out of office' visit using Dx code V68.89 (Encounter for Administrative Exam).

↓

Enter the CPT cod EC894 (Advanced payment received from patient). This CPT has a charge of $0.

↓

Click 'Done' And 'Lock' the out of office encounter.

↓

Create a patient payment and apply payment to the out of office encounter just created (visit can be found by click the 'visits' button).

↓

If patient makes partial payment on encounter multiple times, biller can always apply the payment to same encounter.

↓

While billing for service, add CPT code EC111 (Move payment from another claim) before locking the encounter.

↓

Enter billing notes stating which service date the payment has to be moved from and also the amount.

Note: Can create a 'billing alert' to remind front office that patient has already made payment for a future date.

APPENDIX A: NOTICES

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